

City of Miami Beach Group Health Change Form

Class/Division _____

Last Name

[illegible]

First Name

[illegible]

MI

7

Social Security Number

$$\begin{array}{|c|c|c|} \hline & & \\ \hline \end{array} - \begin{array}{|c|c|} \hline & \\ \hline \end{array} - \begin{array}{|c|c|c|c|} \hline & & & \\ \hline \end{array}$$

City ID Number

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Street Address

[illegible]

Apt/Suite/PO box number

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City

[illegible]

State

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Zip Code

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County

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- ☐ Add dependent (complete Dependent information form and any applicable enrollment forms).
- ☐ Delete dependent (complete Dependent information form and any applicable enrollment forms).
- ☐ Cancel coverage effective ____ / ____ / 20 ____.

Qualifying Life Event

Qualifying Life Event:

- ☐ Marriage/Domestic Partner (must provide copy of Marriage License or Certificate. Must be newly registered Domestic Partner.)
- ☐ Birth or adoption (must provide copy of footprint, birth certificate, certificate of adoption or proof of placement in your home for adoption.)
- ☐ Divorce/ Legal Separation (must provide copy of divorce or separation agreement.)
- ☐ Spouse's employer terminates or no longer contributes to coverage
- ☐ Spouse change from full-time to part-time employment
- ☐ Spouse terminates employment
- ☐ Dependent's death
- ☐ Other

Date of Qualifying Life Event (MM/DD/YYYY)

____/____/20____

Medical – Does not apply to Police and Fire Employees.

Change Plan from:

Coverage Type ☐ Premium HMO ☐ Standard HMO ☐ Premium PPO

☐ Standard PPO ☐ POS ☐ No Coverage

Coverage Level ☐ Employee Only ☐ Family ☐ No Coverage

Change Plan To:

Coverage Type ☐ Premium HMO ☐ Standard HMO ☐ Premium PPO

☐ Standard PPO ☐ POS ☐ No Coverage

Coverage Level ☐ Employee Only ☐ Family ☐ No Coverage

Dental– Does not apply to Fire Employees

Change Plan from:

Coverage Type ☐ DHMO ☐ PPO ☐ No Coverage

Coverage Level ☐ Employee Only ☐ Employee + 1 ☐ Family

Change Plan To:

Coverage Type ☐ DHMO ☐ PPO ☐ No Coverage

Coverage Level ☐ Employee Only ☐ Employee + 1 ☐ Family ☐ No Coverage

Life Insurance – You may elect Supplemental Life Insurance from 1 to 5 times your annual pay. In addition, you may also elect life insurance for your spouse and/or your dependent children. Coverage requests may be subject to insurance carrier approval.

Supplemental Life Insurance - You may elect 1 times to 5 times your annual pay.

☐ 1x Annual Pay ☐ 2x Annual Pay ☐ 3x Annual Pay ☐ 4x Annual Pay

☐ 5x Annual Pay ☐ No Coverage

Dependent Life Insurance - You may elect coverage for your spouse and dependent children.

☐ \$20,000 spouse/\$10,000 child(ren) ☐ \$30,000 spouse/\$10,000 child(ren)

☐ \$40,000 spouse/\$10,000 child(ren) ☐ \$50,000 spouse/\$10,000 child(ren)

☐ No Coverage

Disability Insurance – You may elect Short-Term Disability and/or Long-Term Disability coverage. Your coverage and premium are based on your annual pay.

☐ **Short-Term Disability**

☐ **Long-Term Disability**

☐ **No Coverage**

Replaces 60% of your weekly pay

Replaces 60% of your monthly pay

Primary Care Physician (HMO and POS Only)	Physician ID	Current Patient? Yes <input type="checkbox"/> No <input type="checkbox"/>
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Compensation Reduction Agreement

I agree that my pay will be reduced by the amount of my required contribution for the benefit option(s) I have elected. The amount of my required bi-weekly contributions for each benefit option I have elected has been provided to me by Human Resources. I also understand the following:

- My premium contributions are taken from my payroll before taxes are calculated. I understand I cannot change or revoke this benefit election or compensation reduction agreement as of any date prior to the next Annual Open Enrollment, unless I have a qualified change in family status (qualified life event) such as the birth or adoption of a child, marriage, divorce, death of my spouse, a reduction in hours, or termination of my spouse's employment. Eligibility for Medicare for my spouse or me does not constitute a qualified life event. I will notify Employee Benefits within **30 days of the qualifying event** to make any necessary changes to my elected coverage. I also understand documentation will be required for verification.
- The establishment of and my subsequent participation in a union sponsored medical or dental plan during the plan year will not change my plan participation at that time.
- If my required contributions for my elected benefits are increased or decreased while this agreement remains in effect, my pay will automatically be adjusted to reflect the increase or decrease in premium.
- During the Annual Open Enrollment each year I will be provided the opportunity to change my benefit elections for the following Plan Year. If I do not complete and return an election form during that time, I will be treated as having elected to continue the benefit coverage then in effect and the associated required contributions, unless otherwise required by the City.
- The Plan Administrator may reduce or cancel the amount of my payroll contributions or otherwise modify this agreement if the Administrator believes it is advisable in order to satisfy provision or changes in the provisions of the Internal Revenue Code.
- I am responsible for the associated contributions for all the benefit coverage I elect, and understand my coverage elections may be terminated should my bi-weekly compensation be reduced to a level insufficient to cover the cost of my elected coverage.
- The reduction in my cash compensation under this agreement will be in addition to any other reduction under any other agreements or benefit plans.
- I understand that any misrepresentation of the eligibility of my dependents may result in my loss of eligibility under the City of Miami Beach Group Health Plan and may also result in disciplinary action up to and including termination of my employment.

Signature

Employee Signature

Date